Quality Management Overview for Students
Tift Regional Health System’s Quality Management Program strives to assure quality patient safety and care while lessening organizational risk. The Quality Management Program requires a team effort on the part of every Tift Regional employee on every campus of the organization. Each department within the organization must participate in quality improvement performance to assure the department and organization are staying up to date with standards of care. Students and faculty are a part of the team to assure patient safety.
Objectives

At the conclusion of this cbl the student and faculty member should be able to:

1. Identify the four components of Quality management.
2. Discuss the components of risk management.
3. Define Sentinel Event.
4. Outline Focus PDCA.
5. Discuss National Patient Safety Goals.
Quality Management requires the efforts of all personnel working together, communicating and being active in activities that enhance performance.

It involves five components:

- Risk Management
- Performance Improvement
- Case Management
- Accreditation Readiness
- Patient Safety
Everyone participates in Risk Management. How?

- Identify risky situations, negative trends and try to avoid them.
- Use occurrence forms to report any unusual events.
- Report unusual events to your manager.
Everyone participates in Performance Improvement. How?

- Look for ways to improve performance and processes. Everything we do ultimately impacts patient care.
Risk Management

Risk management indicators may include:

– Patient falls
– Medication errors
– Procedure errors
– Surgery discrepancies
– Lawsuits/claims
– Patient/family complaints
Risk Management indicators (cont)

- Employee or guest needle-sticks
- Employee or guest back injuries
- Security incidents
- “Near Misses”
- Sentinel events
- Unattended Births
- Inability to reach physicians responsible for patient care
Risk Management

- An **Occurrence Reporting System** is used to record unusual events especially those associated with risk indicators.

- The occurrence reporting system is non-punitive and does not include the names of the reporting individual or those individuals involved.

- Emphasis is on identification of risk and prevention of injury.

- Risk Management **MUST BE** notified of any patient injury.
Note:
If the patient injury involves death or permanent loss of function, not related to the natural course of the patient’s illness or underlying condition, it is always considered to be a sentinel event and may be reported to external agencies such as the Joint Commission and/or the Georgia Department of Regulatory Services.
Examples of Sentinel Events

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error.

- Suicide of any individual receiving care, treatment or services in an around-the-clock setting or within 72 hours of discharge.

- Any elopement or unauthorized departure from an around-the-clock care setting which results in suicide, accidental death, homicide or major permanent loss of function.

- Unanticipated death of a full-term infant.

- Any intrapartum maternal death (i.e. related to the birth process).
Sentinel Events

- Assault, homicide or other crime resulting in patient death or permanent loss of function

- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
In addition, there are some events that are considered so critical that they are always treated as sentinel events even if the patient survives without permanent loss of function. Examples of these are listed on the next two slides.
Sentinel Events

- Discharge of an infant to the wrong family
- Abduction of any individual receiving care, treatment or services
- Rape (not alleged)
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient, wrong side or wrong body part
Sentinel Event

- Unintended retention of a foreign object, such as a sponge or forceps, in a patient after surgery or other procedure.

- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).

- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.
Events are called "sentinel" because they signal the need for immediate investigation and response.

**ALL of these events are reviewable by Joint Commission and must be reported immediately to Risk Management.**
A Near Miss is an event that carries a significant chance of serious adverse outcome.

Simply put, a near miss is a sentinel event that almost happened.

Near misses are performance improvement gifts……a chance to correct serious process flaws BEFORE anyone actually gets hurt.
Actions To Take

- If a sentinel event or near miss occurs the student or faculty member should:
  - Provide appropriate care for the individual affected by the event.
  - Report immediately to the Nurse Manager of the unit and the Nursing Supervisor the event (the Nursing Supervisor will notify the Risk Manager).
  - Contain any risk: take action to prevent the repetition of the event.
  - Follow guidelines provided by TRMC/CMC staff.
Sentinel Event or Near Miss

- Preserve evidence: secure any biological specimens, medications, equipment, medical or other records, and any other material that might be relevant to investigating the failure.
Communication and Disclosure

• Supervisors, Risk Management and Administrators will determine how best to notify other parties, including outside agencies.

• Patient disclosure is the responsibility of the attending physician, and can be delegated to the Patient Representative, Risk Management, VP Medical Affairs or to Nursing.

• Employee Support/Assistance is offered immediately and coordinated through the Human Resources office.

• A root cause analysis is conducted within 45 days.
Continual improvement and risk reduction is the goal of Quality Management.

Everyone participates in Performance Improvement.

Look for ways to improve performance and processes. Everything we do ultimately impacts patient care.

Two approaches used to study and eliminate potential risks for the hospital include:

- Focus PDCA
- FMEA
- Lean /Six Sigma (DMAIC) Process
Focus PDCA

- Find an improvement opportunity.
- Organize the study and identify the team.
- Clarify the knowledge of the process.
- Understand the data.
- Select an intervention based on data.
- Plan an intervention that responds to the analysis of data.
- Do a pilot of the intervention.
- Check the results.
- Act to hold the gain and continue improvement.
This approach takes one high risk process per year and analyzes the risk and strategies to prevent injury. Past FMEAS have focused on medication reconciliation, home fire safety related to oxygen use by hospice patients, fall reduction, and decubiti (pressure ulcers) prevention.
Lean/Six Sigma (DMAIC) process focuses on removing waste from the system (Lean) and reducing variability within the system through standardization of work processes (Six Sigma). This is accomplished using the DMAIC process.

- Define
- Measure
- Analyze
- Improve
- Control
• Doctor Ready is our signal that JC has officially entered our building for an unannounced survey.

• When Doctor Ready is announced, all department personnel should quickly double check their status and prepare for the surveyors to visit their area.

• Consult your department manager for more information on the Doctor Ready / Survey Readiness Plan for your area.
National Patient Safety Goals

- Each year Joint Commission, in collaboration with the Institute for Safe Medication Practices and the International Center for Patient Safety, establishes National Patient Safety Goals for healthcare organizations. The goals are based upon standards of care, identified health care issues and reported data regarding sentinel event occurrences. Accreditation standards are defined for each goal and surveyors will “trace” key elements that validate the consistency of safety practices across all of TRMC/CMC’s campuses and services.
Current NPSGs

• **Improve accuracy of patient identification**
  – 2 patient identifiers used prior to specimen collection, medication administration, transfusion, or treatment.
  – Patient room number or physical location is **never** used.
  – Specimens labeled in presence of patient.
  – Involve patient/family in process.

• **Eliminate transfusion errors related to patient misidentification.**
  – Applies to all blood or blood component transfusions.
  – Blood to patient match uses 2 person bedside/chair-side process, one of whom must be the person who will be administering the transfusion.
  – ID process must be completed after the blood is dispensed but prior to starting the transfusion.
Current NPSGs

• Improve effectiveness of communication among caregivers.
  – Write down, read back, verify process for verbal orders and telephone test results.
  – Designated Do Not Use Abbreviation List.
  – Timely reporting of critical tests, results, and values.
  – Standardized hand-off process with opportunity to ask and respond to questions.

• Improve the safety of using medications.
  – Remember to physically separate look alike sound alike drugs (multiple vials of insulin is a favorite “hot item” for surveyors).
  – Label all medications and solutions used on and off the sterile field.
  – Implement a defined anticoagulant management program throughout the organization.
Current NPSGs

• Reduce risks of healthcare-associated infections by following hand hygiene guidelines. Note that observation of staff technique and timing is a current “hot item” with surveyors.

• Implement evidenced-based practices to reduce the incidence of infections associated with multiple drug-resistant organisms (MDROs), central lines, and surgical site infections.
• Accurately & completely reconcile medications across the continuum of care.
  – Identified discrepancies are reconciled and documented.
  – An up-to-date reconciled medication list must be communicated to the next provider as part of the handoff process whenever the patient is transferred within the hospital.
  – Patient education regarding updated home medication list is documented at time of discharge, includes the need to discard old lists and update any records with all medication providers or retail pharmacies.

• Reduce risk of patient harm resulting from falls.

• Define/communicate means for patients to report concerns about safety and encourage them to do so.
  – Information included in patient rights and responsibilities info received during registration and also posted on public TRMC website.
Current NPSGs

• Provide patient and family education regarding infection control practices related to hand hygiene, respiratory hygiene, and contact precautions according to the patient’s condition.
  – On the day of admission or as soon as possible.
  – May use any form of media.
  – Understanding of information is evaluated and documented.

• Provide surgical patients with education regarding the measures that will be taken to prevent adverse events in surgery such as patient identification process, site marking, and prevention of surgical infections.
  – May use any form of media.
  – Understanding of information is evaluated and documented.

• Encourage family and patient participation in rapid assessment team notification.
Current NPSGs

• Identify safety risks inherent in patient population.
  – Patients at risk for suicide.
    • Identified by either seeking treatment as a result of attempted suicide OR by verbalizing intent to staff member.
    • Treatment with one on one observation by security or other non-licensed staff.
    • Provide information regarding local crisis hotlines, if available.
  – Patients at risk for home fires re: use of oxygen
    • Hospice in home assessment process.
    • Patient/Family education.
Current NPSGs

- Implement universal protocol requirements for preventing wrong site surgery.
  - Surgical sites are marked by a licensed independent practitioner or other provider who is privileged/ permitted to perform the intended procedure AND who will be present at the time the procedure will be performed.
  - Final time out expanded to include:
    - Correct patient identity.
    - Confirmation that correct site and side are marked.
    - An accurate procedure consent form.
    - Agreement on the procedure to be done.
    - Correct patient position.
    - Relevant images and results properly labeled and appropriately displayed.
    - The need to administer antibiotics or irrigation fluids.
    - Safety precautions based on patient history or medication use.
For additional information about the Quality Management Program at Tift Regional Health System, the student or faculty member may:

- Review information posted on the MedNet under Quality Management.
- Talk with a department supervisor or manager in the area.
- Contact the QM Director (ext. 6119)
- Contact the hospital’s Joint Commission Coordinator (ext. 6413)